

Bridging the Post-Resuscitation Care Gap is the Key to Increasing Survival Rates for In-Hospital Cardiac Arrest (IHCA) Patients

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Background

While clinical teams successfully achieve Return of Spontaneous Circulation (ROSC) in 52% of adult patients, a critical systemic drop-off occurs after resuscitation, leaving the final survival-to-discharge rate at just 26%.

Based on the latest National Cardiac Arrest Audit (NCAA) and the Resuscitation Council UK Guidelines 2025, this article details the vulnerabilities within hospital structures and outlines the strategic actions required to secure the patient care continuum.

The dual vulnerabilities: Ward gaps and silent deterioration

A staggering 56.6% of all in-hospital cardiac arrests occur on general wards, where patients are largely unmonitored compared to intensive care environments. This lack of continuous surveillance drives two major clinical anomalies:

- **The 06:00 arrest spike:** Data highlights a sharp surge in cardiac arrests around 06:00. This occurs because unmonitored ward patients deteriorate silently overnight and are discovered only during morning nursing rounds.
- **The off-peak survival deficit:** Due to reduced clinical staffing and delayed responses, patient survival drops significantly during off-peak windows—falling to 13.8% at night (vs. 23.0% during the day) and 16.1% on weekends (vs. 19.3% on weekdays).
- **Non-shockable rhythm dominance:** Pulseless Electrical Activity (PEA) and asystole comprise 72% of adult ward arrests. These rhythms carry a dismal 10.5% to 16% final survival rate and serve as the medical system's signature indicator of prolonged, unnoticed cardiopulmonary decline.

Overhauling hospital at night workflows

To eliminate the early morning surveillance gap, clinical operations must establish standard proactive monitoring safety nets.

1. **Staggered vitals checks:** Standardise nursing rotas to mandate active National Early Warning Score (NEWS2) monitoring across all general medical-surgical wards between 03:00 and 05:00.
2. **Night outreach teams:** Fully fund 24/7 Critical Care Outreach Teams (CCOT) through regional Integrated Care Boards (ICBs) to actively audit ward charts overnight rather than waiting for automated crisis calls.

3. **Clinical worry overrides:** Empower junior foundation doctors and ward nurses to rapidly escalate care if a patient appears physically unwell, completely bypassing rigid physiological thresholds.

Securing the post-ROSC care pathway

Hospitals must treat the return of a heartbeat not as a successful conclusion, but as the initial phase of an ultra-critical recovery pathway.

Vulnerable Patient Cohort	Current Performance (NCAA)	Resuscitation Council 2025 Mandate	Operational Trust Action	Primary Metric
Adult Post-ROSC Patients	52% achieve ROSC; 26% survive to discharge.	Structured ABC approach; regionalized care networks.	Rigidly enforce ICU for 36-72 hours.	Reduction in blood pressure (systolic the post>100 mmHg) and active ROSC fever control ($\leq 37.5^{\circ}\text{C}$) mortality gap.
Adult NonShockable Rhythm (PEA/Asystole)	44% initial ROSC; 16% final discharge survival.	Early identification of reversible, noncoronary triggers.	Deliver early adrenaline; mandate immediate whole-body CT scans to identify underlying causes.	Increase nonshockable hospital survival past 16%.
Adult Shockable Rhythm (VF/VT)	77% sustained ROSC; 54% survival to discharge.	Prioritise emergency coronary interventions.	Standardise direct-to cath-lab pathways for patients with ST elevation or high occlusion suspicion.	Increase shockable hospital survival past 54%.

Table

Securing the step-down safety net

Once a post-arrest patient stabilises enough to leave the intensive care unit, the stepdown environment must be fortified. Hospitals must transition completely from paper tracking to electronic health records with automated track-and-trigger telemetry. Any patient stepped down from the ICU to a general ward must wear wireless, continuous heart rate and respiratory telemetry patches for the first 72 hours.

Furthermore, to eliminate false clinical pessimism, medical teams must delay definitive neuro-prognostication until at least 72 hours post-ROSC by utilising a strict multimodal matrix of clinical examinations, EEGs, biomarkers, and neuroimaging [1-3].

Disclaimer

This article provides general medical information based on audit data and resuscitation guidelines for educational purposes; it does not constitute clinical advice or personalized patient-care recommendations.

Bibliography

1. Resuscitation Council UK 8 Edition.
2. Gavin Perkins and Adam Benson Clarke. "Executive summary of the main changes since the 2021 Guidelines" (2025).
3. Jerry P Nolan., *et al.* "Incidence and outcome of in-hospital cardiac arrest in the United Kingdom National Cardiac Arrest Audit". *Resuscitation* 85.8 (2014): 987-992.

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